SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

☐ **MR** ☐ **RD** ☐ **Autism** ☐ **TBI** ☐ **SCI** ☐ **SD** ☐ **Other**

REQUEST FORM—INDIVIDUAL AND FAMILY SUPPORT STIPEND

Consumer: _____

Local Provider: _____

DSN/Home Board: _____

Local Provider Action

Received Date: _____ **Review Date:** _____

☐ **Approved** **Amount: $**_____ **Approved Period:** _____

☐ **Denied (See reason below)** ☐ **No Action, Return to Referring Staff (See below)**

Comments: _____

_____

_____

_____

_____

_____

_____ _____

DSN/Home Board Provider Administrator Date

DDSN/Home Board If Different From Above

Received Date: _____ **Review Date:** _____

☐ **Approved** **Amount: $**_____ **Approved Period:** _____

☐ **Denied (See reason below)** ☐ **No Action, Returned to Referring Staff (See below)**

Comments: _____

_____

_____

_____

_____

_____

_____ _____

DSN/Home Board Provider Administrator Date

Form #350 (Revised) July 2006

Provider Information

Referring Provider Staff: _____ **Phone: ( )** _____

Local Provider: _____

DSN/Home Board: _____

Consumer Information

Name: _____ **Age/Birth Date:** _____

Address: _____ **Phone: ( )** _____

_____ **Medicaid #:** _____

SS#: _____

Number residing in household _____

Members of Household: Relationship/Age

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Check All That Apply:

☐ **DDSN Eligible**

☐ **DDSN-Eligible High Risk**

☐ **Medicaid Eligible**

☐ **HASCI Waiver Participation**

☐ **CLTC Waiver Participation**

☐ **Waiver Enrollment Pending**

☐ **Medicaid Eligibility Pending** ☐ **Waiver Waiting List - Critical**

☐ **MR/RD Waiver Participation** ☐ **Waiver Waiting List – Non-Critical**

☐ **Applying for DDSN services and requires interpreter services**

Is the consumer currently employed? ☐**Full-time** ☐**Part-time** ☐ **No**

Monthly Household Income/Expense

(If additional space is necessary, attach worksheet to this form)

Income Sources	Amount	Major Expenses	Amount
		Essential Expenses	
_____	_____	Housing	_____
_____	_____	Utilities	_____
_____	_____	Food	_____
_____	_____	Car Loans	_____
		Non-Essential Expenses	
_____	_____	Loans	_____
_____	_____	Credit Cards	_____
_____	_____	Cable/Cell Phones	_____
_____	_____	Recreational/Other	_____
Total Monthly Income (Attach copy of Income verification)	_____	**Total Monthly Expense**	_____

Net Balance (Income minus Expenses) **$**_____

(Describe how Consumer's SSI Income is used) _____

_____

_____

I certify that the above consumer information is true and complete. I understand that submitting false information or use of Individual and Family Support Funds for purposes other than as requested may result in termination of assistance and a payback of expended funds to DDSN.

Consumer or Parent or Legal Guardian **Date**

Request Information

Type Request	Amount Needed	Amount Requested	Approval Period
☐ One-Time	$_____	$_____	_____
☐ Ongoing *	$_____	$_____	_____

***(Provide detail information about costs of items requested.)**

Service Category

- ☐ Assistive Technology/Assessment
- ☐ Medical Care/Allied Medical Care/Medical Supplies
- ☐ Personal Care Aide/Attendant Care
- ☐ Environmental Modification/Assessment
- ☐ Respite Care/Sitter Services
- ☐ Special Needs Child Care Cost
- ☐ Other (Specify) _____

Justification

Explain how out-of-home placement will be avoided unless request is for temporary funding while awaiting critical placement. Explain what the child/individual does during the day and if he/she is in school.

Assurance of Resource Review

Other resources utilized/contributed to assist with requested need:

☐ **Consumer/Family**	**Amount $**_____
☐ **Private Insurance/Medicare/Medicaid**	**Amount $**_____
☐ **Private, Non-Profit (Specify)** _____	**Amount $**_____
☐ **Public Agency (Specify)** _____	**Amount $**_____
☐ **Social Security PASS (Plan for Achieving Self Support)**	**Amount $**_____
☐ **IRWE (Impairment Related Work Expense)**	**Amount $**_____
☐ **Other (Specify)** _____	**Amount $**_____

_____ _____

Referring Provider Staff **Date**

_____ _____

Reviewing Supervisor **Date**